

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- ☐ Name or update your beneficiary
- ☐ Reduce the amount of your insurance coverage
- ☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name First name Middle name

Rank, title or grade

Social Security Number

Branch of Service (Do not abbreviate)

Current Duty Location

Amount of Insurance

By law, you are automatically insured for \$250,000. **If you want \$250,000 of insurance**, skip to *Beneficiary(ies) and Payment Options*. **If you want less than \$250,000** of insurance, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. **If you do not want any insurance***, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

- ☐ I want coverage in the amount of \$_____ Your initials_____
- ☐ _____

(Write "I do not want Insurance at this time.")

***Note:** Reduced or refused insurance can be *only* be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements and will also affect the amount of VGLI you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1.				
2.				
Contingent				
1.				
2.				
3.				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- **This form cancels any prior beneficiary or payment instructions.**
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$250,000.

SIGN HERE IN INK



(Your signature. Do not print.)

Date: _____

Do not write in space below. For official use only.

WITNESSED AND RECEIVED BY:

RANK, TITLE OR GRADE

ORGANIZATION

DATE RECEIVED

Please read the instructions before completing this form.

Family Coverage Election

Servicemember's Information

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number
Branch of Service (Do not abbreviate)				Rank, title or grade

Amount of Insurance

Family Coverage for Dependent Child(ren). By law, if you are insured under SGLI, each of your dependent children (see page 3 for a definition of dependent children for SGLI purposes) is automatically insured for \$10,000.

Family Coverage for Spouse. By law, if you are insured under SGLI, **your spouse is automatically insured for \$100,000 or the amount of your SGLI coverage**, whichever is less. **If you want less than the automatic amount of coverage for your spouse**, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. **If you do not want any coverage for your spouse***, check the appropriate block below and write (in your own handwriting), "I do not want coverage for my spouse at this time."

☐ I want coverage in the amount of \$ _____

☐ _____
(Write "I do not want coverage for my spouse at this time.")

***Note:** Reduced or refused family coverage can *only* be restored by completing form SGLV 8285A with proof of good health and compliance with other requirements. It will also affect the amount of insurance your spouse can convert to when Family Coverage expires.

Spouse's Information

(To be completed by member. It is not necessary to complete this section if you're declining coverage.)

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number
Date of Birth (dd-mmm-yyyy e.g. 24-AUG-1965)				

Premiums for Spousal Coverage

Spouse's age:	Monthly rate per \$10,000	Monthly cost for \$100,000 coverage
Under 35	\$.90	\$9.00
35-44	\$1.30	\$13.00
45-49	\$2.00	\$20.00
50-54	\$3.20	\$32.00
55 & older	\$5.50	\$55.00

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form and certify that the information I have provided is correct.

SIGNATURE OF SERVICEMEMBER ➤ _____

Date: _____
(dd-mmm-yyyy
e.g. 01-NOV-2001)

Do not write in space below. For official use only.

Witnessed and received by: (please print)	Rank, title or grade	Organization	Date Received (dd-mmm-yyyy e.g. 01-NOV-2001)
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